	1. TRANSMITTAL NUMBER:	2. STATE:
TRANSMITTAL AND NOTICE OF APPROVAL OF	0 0 — 0 0 6	Nebraska
STATE PLAN MATERIAL	3. PROGRAM IDENTIFICATION: TITL	
FOR: HEALTH CARE FINANCING ADMINISTRATION	SECURITY ACT (MEDICAID)	E XIX OF THE SOCIAL
	CEGOTITY AGT (MEDIGAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION		
DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 1, 2000	
5. TYPE OF PLAN MATERIAL (Check One):		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CON	SIDERED AS NEW PLAN 🙀 🗚	MENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENU	MENT (Separate Transmittal for each ame	endment)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
	a. FFY 2000 \$ Ø	
	b. FFY <u>2001</u> \$ <u>Ø</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSE	DED PLAN SECTION
Att: 3.1A, Att: 4.19B	OR ATTACHMENT (If Applicable):	
	Att: 3.1A, Att: 4.19B	
	1.000 00000, 1.000 0000	
10. SUBJECT OF AMENDMENT:		
Telehealth		
11. GOVERNOR'S REVIEW (Check One):		
•	OTHER ACCRECISED.	
GOVERNOR'S OFFICE REPORTED NO COMMENT	★ OTHER, AS SPECIFIED:	
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
12. SIGNATURE OF STATE AGENCY OFFICIAL,	B. RETURN TO:	
Kolont 1 deillet	HHS F&S	
13. TYPED NAME:	Medicaid Division	
Robert J. Seiffert	Attn: Dana McNeil	
14. TITLE:	P.O.Box 95026	
Medicaid Administrator	Lincoln, NE 68509-5026	
15. DATE SUBMITTED: 25		•
August 30, 2000		
FOR REGIONAL OFFI		
17. DATE RECEIVED: The one relit arom II switch the composition of the one of	MAR 1 6 7IIII	Track 19 . Edective Date of
PLAN APPROVED - ON		
19. EFFECTIVE DATE OF APPROVED MATERIAL: Abold 6 2	O SIGNATURE OF RESIDNAL OFFICIAL	en to yourself the
	and soft	No-
	2/TITLE:	
Thomas W. Lenz	ARA for Medicaid and State	uperations
23. REMARKS: vose; state ovitosite eno estit enor llavorque istinca s.	the brack to reservence see and in drawas	Paul Francis Const
cc:		decird, use bond paper
Raymond	SPA CONTROL	
Seiffert		
per section and an additional street of the section	Pate. Submitted 08/28/00	fles with and tradeing the order order.
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Revision: HCFA-PM-91-

HCFA ID:

7986E

(BPD)

ATTACHMENT 3.1-A

			1991					Page 1 OMB No.: 0938
State/1	Territory	:	Nebras	ska				
	AM						CAL AND REME EGORICALLY I	
1.	Inpatie	nt hosp	ital serv	vices oth	ner than those p	provide	d in an institutio	n for mental diseases.
	Provid	ed:		No limi	tations	<u>X</u>	With limitations	s*
2.a.	Outpat	ient hos	spital se	ervices.				
	Provid	ed:		No limi	tations	<u>X</u>	With limitations	s *
b.					nd other ambula cluded in the St			d by a rural health
	<u>X</u>	Provid	ed:		No limitations	<u>X</u>	With limitations	s*
		Not pro	ovided.					
C .	covere	d under	the pla	in and fi	ter (FQHC) ser urnished by an A-Pub. 45-4).	vices a FQHC i	nd other ambula in accordance w	atory services that are vith sec. 4231 of the
	Provid	ed:		No limi	tations	<u>X</u>	With limitation	s*
3.	Other	laborato	ory and	x-ray se	rvices.			
	Provid	ed:		No limi	tations	<u>X</u>	With limitation	s *
					. •			
							•	
*Desc	ription p	rovided	on atta	chment				
TN NO	D. <u>MS-0</u>	0-06		···		.04		
Super	sedes		Appro	vai Date	MAR 13 20	ן טון	Effective Date	UL 1 2000
TN NO	D. <u>MS-9</u>	2-1						

HCFA-PM- 93-5 MAY 1993

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ATTACHMENT 3.1-A Page 2 OMB NO:

State/Territory:	Nebraska						
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1A	ND REMEDIAL				O THE CATEGORICALLY NEEDY	
4.a.	Nursing facili individuals 21	•		vices in a	in institution for mental diseases) for	,
	Provided:	No li	mitations	<u> X</u>	With limitations*	
b.			g, diagnostic and anditions found		nt services for individuals under 21 years	i
	Provided:	No I	mitations	X_	With limitations	
C.	Family planni	ng services a	nd supplies for	individual	ls of child-bearing age.	
	Provided:	No	limitations	X_	With limitations*	
5. a.	Physicians' se facility or else		er furnished in t	he office, t	the patient's home, a hospital, a nursing	}
	Provided:	No I	imitations	<u>X</u>	With limitations*	
b.	Medical and 1905(a)(5)(B		rvices furnishe	ed by a	dentist (in accordance with section	1
	Provided:	No I	imitations	_X_	With limitations*	
6.					ecognized under State law, furnished by tice as defined by state law.	/
a .	Podiatrists' s	ervices.				
	Provided:	No	limitations	X_	With limitations*	
* Des	scription provide	ed on attachm	ient.			
TN N	O. <u>MS-00-06</u>					-
Supe	rsedes	Approval D	ate <u>MAR 16</u>	2001	Effective Date 1 2000	
TN N	O. <u>MS-93-11</u>					
HCF	A ID: 7986	E				

HCFA-PM-91- 4 **AUGUST 1991**

(BPD)

ATTACHMENT 3.1-A

Page 3 OMB No.: 0938-

		State	e/Territo	ry: Nebraska		
AN	ID REME			RATION, AND S		EDICAL CATEGORICALLY NEEDY
b.	Optome	trists' services	3 .			
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
		Not provided.				
c.	Chiropra	actors' service	es.			
	_X	Provided:		No limitations	_X_	With limitations*
		Not provided.				
d.	Other p	ractitioners' se	ervices.			
	X_	Provided:	Identifi	ed on attached s	heet with de	scription of limitations.
		Not provided.				
7.	Home h	nealth services	5 .			
a.				ing services prov me health agenc		me health agency or by a e area.
	<u>X</u>	Provided:		No limitations	<u>_X</u>	With limitations*
b.	Home I	nealth aide se	rvices p	rovided by a hom	ne health age	ency.
	X	Provided:		No limitations	<u>X</u>	With limitations*
C. 1	Medica	ıl supplies, eq	uipment	, and appliances	suitable for t	use in the home.
	<u>X</u>	Provided:		No limitations	<u>X</u> _	With limitations*
*Desc	cription p	rovided on atta	achmen	t.		
TN N	O. <u>MS-00</u>	0-06				
	rsedes		val Dat	MAR 1 6 2001	Effec	tive Date JUL 1 2000

TN NO. MS-91-24

HCFA ID:

7986E

HCFA-PM-91-4 AUGUST 1991 (BPD)

ATTACHMENT 3.1-A

Page 3a

OMB No.: 0938-

AN	D REM		UNT, DI	JRATION, AND SC		EDICAL CATEGORICALLY NEEDY
d.				al therapy, or speed gency or medical re		y and audiology services facility.
	<u>_x</u> _	Provided:		No limitations	<u>_X</u> _	With limitations*
	_	Not provided.				
8.	Private	duty nursing	services	3.		
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
		Not provided				

TN NO. MS-00-06

Supersedes

Approval Date MAR 1 6 2001

Effective Date 1 2000

TN NO. MS-93-15

HCFA ID:

7986E

HCFA-PM-85-3 MAY 1985 (BERC)

ATTACHMENT 3.1-A

Page 4

OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9.	Clinic	services.					
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided.					
10.	Dental	services.					
	X	Provided:		No limitations	<u>_X</u> _	With limitations*	
		Not provided.					
11.	Physic	al therapy and	related	services.			
a.	Physic	al therapy.					
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided.					
b.	Occup	ational therapy	···	en more transfer of the second			
	X	Provided:		No limitations	_X_	With limitations*	
		Not provided.					
C.				speech, hearing. beech pathologis		e disorders (provided by or t).	
	X	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided.					
*Desc	ription p	provided on atta	achmen	t.			
TN NO	D. <u>MS-0</u>	0-06					
Super	sedes	Appro	val Dat	MAR 16 2001	Effecti	ve Date JUL 1 2000	
TN N	D. <u>MS-9</u>	0-14					
HCFA	ID:	0069P/0002P	•				

12.

HCFA ID:

0069P/0002P

HCFA-PH-85-3 MAY 1985

(BERC)

ATTACHMENT 3.1-A

Page 5

OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

2.				and prosthetic dev of the eye or by a		eglasses prescribe t.	ed by a
a.	Presci	ribed drugs.				~	
	<u>X</u>	Provided:		No limitations	_X_	With limitations*	
		Not provided.					
b.	Dentu	res.					
	<u>X</u>	Provided:		No limitations	_X_	With limitations*	
		Not provided.					
C.	Prosth	netic devices.					
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
	 . ·	Not provided.					
d.	Eyegl	asses.					
	<u>X</u>	Provided:		No limitations	<u>. X</u>	With limitations*	
		Not provided.					
13.		· diagnostic. scr ded elsewhere i			ehabilitative	services, i.e., othe	r than thos
a.	Diagr	ostic services.					
		Provided:		No limitations		With limitations*	
	<u>X</u>	Not provided					
*Desc	ription	provided on att	achmer	nt.			
TN NO	D. <u>MS-</u> (
Super	sedes	Appro	oval Dat	MAR 1 3 2001	Effect	ive DateJUL 1	<u>2</u> 000
TN NO	D. <u>MS-</u>						

HCFA-PM-85-3 MAY 1985

(BERC)

ATTACHMENT 3.1 -A

Page 6 OMB No.: 0938-0193

AMOUNT, DURATION. AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b.	Scree	ning services.				•	
	X	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided.					
C.	Preve	ntive services.					
		Provided:		No limitations		With limitations*	
	<u>X</u>	Not provided.					
d.	Rehat	oilitative service	es.				
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided		•			
14.	Servi	ces for individu	als age	65 or older in instit	utions for m	ental diseases.	
. a.	Inpati	ent hospital ser	rvices.	- ;			
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided					
b.	Skille	d nursing facilit	y servic	es.			
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided	l.				
C.	Interr	nediate care fa	cility se	rvices.	,		
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*	
		Not provided	i.				
*Desc	cription	provided on at	tachmer	nt.			
TNN	O. <u>MS</u> -	00-06		MAR 1 6 2001			
Supe	rsedes	Appr	oval Da	te	Effec	tive DateJUL 1 2000	
TN N	O. <u>MS-</u>	95-9					

HCFA-PM-86-20 SEPTEMBER 1986 (BERC)

ATTACHMENT 3.1 -A

Page 7

OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a.	diseas		termine			s in an institution for mental in 1902(a)(31)(A) of the Act, to
	<u>X</u>	Provided: _	1	lo limitations	<u>X</u>	With limitations:
		Not provided.				
b.		ing such services ed or persons with			tinct pa	rt thereof) for the mentally
	<u>X</u>	Provided: _	1	No limitations	<u>X</u>	With limitations:
		Not provided.				
16.	Inpatie	ent psychiatric fac	ility ser	vices for individuals	under 2	2 years of age.
	<u>X</u>	Provided: _	1	No limitations	<u>X</u>	With limitations:
		Not provided.				
17.	Nurs	e-midwife services	s;			
	<u>X</u>	Provided: _	1	No limitations	<u>X</u>	With limitations:
		Not provided.				
18.	Hospi	ice care (in accord	dance w	vith section 1905(o) o	of the A	ct).
		Provided _	ا	No limitations		With limitations:
	<u>X</u>	Not provided.				
Tropo	mittal #	MS-00-06				
				WD 4 6 7681		11/1 4 6363
Super	rsedes	Approva	al Date	MAR 1 G 2001	Effect	ive Date <u>JUL 1 2000</u>
Trans	mittal #	MS-95-13				

HCFA-PM-94-7 SEPTEMBER 1994 (MB)

ATTACHMENT 3.1-A Page 8

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

		State/Territory: Nebraska
ΛA	ID REM	AMOUNT, DURATION, AND SCOPE OF MEDICAL EDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
19.	Case	nanagement services and Tuberculosis related services
a.		nanagement services as defined in, and to the group specified in, Supplement 1 to <u>CHMENT 31-A</u> (in accordance with section 1905(a)(19) or section 1915(g) of the
	X	Provided: X With limitations
		Not provided.
b.	Specia	I tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.
		Provided: With limitations*
	<u>X</u>	Not provided.
20.	Exten	led services for pregnant women
a .		ancy-related and postpartum services for a 60-day period after the pregnancy ends by remaining days in the month in which the 60th day falls.
		Additional coverage ++
b.	Servi	es for any other medical conditions that may complicate pregnancy.
		Additional coverage ++
Attac desc	hed is a ribed in	description of increases in covered services beyond limitations for all groups his attachment and/or any additional services provided to pregnant women only.
*Des	cription	provided on attachment.
TN N	10. <u>MS-</u>	
Supe	ersedes	Approval Date MAR 1 © 2001 Effective Date JUL 1 2000

TN NO. MS-94-15

HCFA-PM-91-

(BPD)

ATTACHMENT 3. 1-A

	1991	Page 8a OMB No.: 0938-
	State/Territory: Nebraska	<u>_</u>
	AMOUNT, DURATION AND SCOPE OF MEDICAL AND REM AND SERVICES PROVIDED TO THE CATEGORICALL	
	Ambulatory prenatal care for pregnant women furnished during a period by an eligible provider (in accordance with section 1920 o	
	X Provided: No limitations _X With	ı limitations*
	Not provided.	
	Respiratory care services (in accordance with section 1902(e)(9) Act).)(A) through (C) of the
	Provided: No limitations With	n limitations*
	X Not provided.	
23.	Certified pediatric or family nurse practitioners' services.	
	Provided: No limitations _X With limitat	ions*
•		

*Description provided on attachment

TN NO. MS-00-06

Supersedes

Approval DateMAR 1 6 2001

Effective Date JUL 1 2000

TN NO. MS-92-1

HCFA ID:

7986E

HCFA-PM-91-4 AUGUST 1991

(BPD)

ATTACHMENT 3.1-A Page 9 OMB No.: 0938

	State/	Territory: <u>Nebr</u>	aska			
AN	ID REM			URATION, AND S RVICES PROVID		EDICAL CATEGORICALLY NEEDY
24.	•	her medical caled by the Seci		any other type of r	emedial care	e recognized under State law,
a.	Transı	oortation.				
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
		Not provided				
b.	Servic	es of Christiar	Scienc	e nurses.		
		Provided:		No limitations		With limitations*
	<u>X</u>	Not provided				
C.	Care	and services p	rovided	in Christian Scien	ce sanitoria.	
		Provided:		No limitations		With limitations*
	<u>_X</u>	Not provided	l.			
d.	Nursi	ng facility servi	ces for	patients under 21	years of age	
	<u>X</u>	Provided:		No limitations	<u>_X</u>	With limitations*
		Not provided	i.			
e.	Emer	gency hospital	service	S.		
	<u>X</u>	Provided:		No limitations	<u>_X</u>	With limitations*
		Not provided	i .	·		
TNN	O. MS-	00-06				
	rsedes		oval Da	MAR 1 6 2001	Effec	tive Date JUL 1 2000

TN NO. MS-91-24

HCFA ID:

7986E

HCFA-PM-94-9

(MB)

ATTACHMENT 3.1-A Page 10

DECEMBER 1994 State: Nebraska AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY Home and Community Care for Functionally Disabled Elderly Individuals. as defined. 25. described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A. Not provided Х Provided Personal care services furnished to an individual who is not an inpatient or resident of a 26. hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home. State Approved (Not Physician) Service Plan Allowed Provided: X Services Outside the Home Also Allowed $\overline{\mathsf{x}}$ Limitations Described on Attachment Not Provided.

TN NO. MS-00-06

Supersedes

Approval Date MAR 16 2001

Effective Date JUL 1 200

TN NO. MS-94-018

a constitute not inter versially of a

ATTACHMENT 3.1-A Page 11

Telehealth Service means any contact between a patient and a health care practitioner relating to health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care providers.

Health care practitioners must:

- 1. act within their scope of practice;
- 2. be enrolled with NMAP; and
- 3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

Medicaid services covered under the State Plan but specifically excluded from telehealth coverage are:

- 1. Medical equipment and supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
- 2. Orthotics and prosthetics provided by DME suppliers and pharmacies;
- 3. Personal Care Aide (PCA) services;
- 4. Home Health Aide services:
- 5. Pharmacy services for prescribed drugs;
- 6. Home and Community Based Waiver services provided by persons that do not meet the standards for practitioner of telehealth services;
- 7. Mental health, substance abuse, and psychiatric rehabilitation services provided by persons that do not meet the standards for practitioner of telehealth services;
- 8. Medical transportation services, including ambulance services;
- 9. Federally Qualified Health Center core services billed as an "encounter" service;
- 10. Rural Health Clinic core services billed as an "encounter" service;
- 11. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification;
- 12. Tribal 638 clinic core services billed as an "encounter" service;
- 13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;
- 14. Services provided in public schools by staff who are not licensed, certified, or registered with Nebraska HHS Regulation and Licensure; and
- 15. Ambulatory room and board services.

Transmittal # MS-0	00-06			
Supersedes	Approved _	MAR 1 8 2001	Effective	JUL 1 2000
Transmittal # (New	v Page)			

ATTACHMENT 3.1-A Page 12

Services provided via telecommunications are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

This requirement does not apply:

- 1. In emergency or urgent medical situations;
- 2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
- 3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

Transmittal # MS-00-06

Supersedes

Approved MAR 1.6 2001 Effective JUL 1 2000

Transmittal # (New Page)

Revision: HCFA-PM-91-1991 (BPD)

ATTACHMENT 3.1-B

Page 2 OMB No.: 0938

State/T	erritory	: <u>Nebraska</u>							
		AMOUNT, DUR MEDICALLY N	ATION AND SCOPE OF EEDY GROUP(S):	SERVICE All groups	ES PROVIDED				
1.	Inpatie	nt hospital service	es other than those provi	ded in an i	institution for mental diseases.				
	<u>_X</u>	Provided:	No limitations	<u>_X</u>	With limitations*				
2.a.	Outpat	ient hospital servi	ces.						
	<u>X</u>	Provided:	No limitations	<u>X</u>	With limitations*				
b.	Rural f	nealth clinic servic which are otherwi	es and other ambulatory se included in the State I	services f Plan)	urnished by a rural health				
	<u>X</u>	Provided:	No limitations	<u>X</u>	With limitations*				
C.	covere	d under the plan a	n center (FQHC) services and furnished by an FQH HCFA-Pub. 45-4).	s and othe IC in accor	r ambulatory services that are dance with sec. 4231 of the				
	<u>X</u> .	Provided:	No limitations	<u>X</u>	With limitations*				
3.	Other	aboratory and x-ra	ay services.						
	X	Provided:	No limitations	<u>X</u>	With limitations*				
4.a.	Nursin individ	g facility services uals 21 years of a	(other than services in ge or older.	n an instit	ution for mental diseases) for				
	<u>X</u>	Provided:	No limitations	<u>X</u>	With limitations*				
b.	Early a of age	and periodic screen , and treatment of	ing, diagnostic and treatn conditions found.*	nent servic	es for individuals under 21 years				
	<u>X</u>	Provided: _	No limitations	<u>_X</u>	With limitations				
C.	Family	planning services	s and supplies for individ	uals of chi	ld-bearing age.				
	<u>X</u>	Provided:	No limitation	<u>_X</u>	With limitations*				
*Descr	iption p	rovided on attach	ment						
TN NC). <u>MS-0</u>								
Supersedes Approval DateMAR 1 6 2001 Effective Date JUL 1 2000									
TN NC	TN NO. MS-92-1								
HCFA ID: 7986E									

Revisio	on: HCFA MAY	PM- 93- 1993	5 (MB)		ATTACH Page 2a OMB NO	
	State/	Territory:	Nebraska			
			JRATION AND SCOI NEEDY GROUP(S):			
5. a.	Physicians' se facility or else		hether fumished in th	e office, the pati	ent's home, a hos	spital, a nursing
	Provided:		No limitations	X With I	imitations*	
b.	Medical and 1905(a)(5)(B)		l services furnished ct).	l by a dentist	(in accordance	with section
	Provided:		No limitation	_X_ With I	imitations*	

TN NO. MS-00-06

* Description provided on attachment.

Supersedes

Approval Date MAR 1 6 2001

Effective Date JUL 1 2000

TN NO. MS-93-11

HCFA-PM-86-20 SEPTEMBER 1986 (BERC)

ATTACHMENT 3.1-B

Page 3 OMB No.: 0938-0193

State/Territory:	Nebraska	
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	AMOUNT, DURATION AND SCOPE OF SE MEDICALLY NEEDY GROUP(S): All cove	
6.	Medical care and any other type of remedial care rec licensed practitioners within the scope of their practic	
a.	Podiatrists' services.	
	X Provided: No limitations	X With limitations*
b.	Optometrists' services.	
	X Provided: No limitations	X With limitations*
C.	Chiropractors' services.	
	X Provided: No limitations	X With limitations*
d.	Other practitioners' services.	
	X Provided: No limitations	X With limitations*
7.	Home health services.	
a.	Intermittent or part-time nursing services provided by registered nurse when no home health agency exists	
	X Provided: No limitations	X With limitations*
b.	Home health aide services provided by a home heal	th agency.
	X Provided: No limitations	X With limitations*
C.	Medical supplies, equipment, and appliances suitable	le for use in the home.
	X Provided: No limitations	X With limitations*
d.	Physical therapy, occupational therapy, or speech perovided by a home health agency or medical rehab	
	X Provided: No limitations	X With limitations*
*Des	cription provided on attachment.	
TN N	O. <u>MS-00-06</u>	
Supe	ersedes Approval Date	Effective Date JUL 1 2000
TN N	IO. <u>MS-86-25</u>	

HCFA-PM-86-20 SEPTEMBER 1986 (BERC)

ATTACHMENT 3.1-B

Page 4

OMB No.: 0938-0193

		State/Territor	y: <u>Neb</u> i	raska						
	M			ON AND SCOPE C ROUP(S): <u>Al</u>		S PROVIDED oups				
8.	Private	Private duty nursing services.								
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*				
9.	Clinic	services.								
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*				
10.	Denta	l services.								
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*				
11.	Physic	cal therapy and	d related	services.						
a.	Physic	cal therapy.								
	<u>X</u>	Provided:		No limitations	<u> X</u>	With limitations*				
b.	Occup	oational therap	y.							
	<u>X</u>	Provided:	_	No limitations	<u>X</u>	With limitations*				
C.				speech, hearing. a peech pathologist (e disorders provided by or st.				
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*				
12.				and prosthetic dev of the eye or by a		yeglasses prescribed by a st.				
a.	Preso	ribed drugs.								
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*				
b.	Dentu	ıres.								

TN NO. MS-00-06

<u>X</u>

Provided:

Description provided on attachment.

Supersedes

Approval DateMAR 1 6 2001

No limitations

Effective Date JUL 1 2000

X With limitations*

TN NO. MS-93-15

HCFA-PM-86-20 SEPTEMBER 1986 (BERC)

ATTACHMENT 3.1-B

Page 5 OMB No.: 0938-0193

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): All covered groups

C.	Prosth	etic devices.				
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
d.	Eyegla	isses.				
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
13.		diagnostic. scr ed elsewhere i			oilitative s	services, i.e., other than those
a.	Diagno	ostic services.		<		
		Provided:		No limitations		With limitations*
	<u>X</u>	Not provided.				
b.	Scree	ning services.			·	
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
C.	Preve	ntive services.				
		Provided:		No limitations		With limitations*
	<u>X</u>	Not provided				
d.	Rehat	oilitative service	es.			
	X	Provided:		No limitations	<u>X</u>	With limitations*
14.	Servic	ces for individu	als age	65 or older in institution	ons for m	ental diseases.
a.	Inpati	ent hospital se	rvices.			
	<u>_X</u> _	Provided:		No limitations	<u>X</u>	With limitations*
b.	Skille	d nursing facilit	y servic	es.		
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
*Desc	ription	provided on att	achmen	t.		
TN NO	D. <u>MS-</u> 0	00-06				
	sedes		oval Dat	MAR 1 6 2001	Effect	ive Date JUL 1 2000

TN NO. MS-95-9

HCFA-PM-85-3 SEPTEMBER 1986 (BERC)

ATTACHMENT 3.1 -B

Page 6 OMB No.: 0938-0193

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEED¥ GROUP(S): ____All covered groups

D.	Intern	nediate care fa	cility ser	rvices.		
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations*
15.a.	disea		s determ			s in an institution for mental on 1902(a)(31)(A) of the Act, t
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations:
b.				public institution (or ated conditions.	distinct pa	art thereof) for the mentally
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations:
16.	Inpati	ient psychiatric	facility	services for individu	als under 2	22 years of age.
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations:
17.	Nurs	e-midwife sen	vices;			
	<u>X</u>	Provided:		No limitations	<u>X</u>	With limitations:
18.	Hosp	ice care (in ac	cordanc	e with section 1905	o) of the A	ct).
		Provided		No limitations	· ——	With limitations:
	X	Not provide	d.			
					•	
Desc	cription	provided on at	tachmer	nt.		
TNN	10. <u>MS</u> -			4 6 2001		_
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TN NO. MS-86-25

HCFA-PM-94-7 SEPTEMBER 1994 (MB)

ATTACHMENT 3.1-B Page 7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

				· · · · ·) THE 00	OIAL OLC	,01(1117	CI	
		State/	Territory:	<u>Nebraska</u>					
	N			ON AND SCO ROUP(S):				D ——	
19.	Case	managemen	t services	and Tubercul	osis related	services			
a.	Case management services as defined in, and to the group specified in, Supplement 1 to <u>ATTACHMENT 31-A</u> (in accordance with section 1905(a)(19) or section 1915(g) of the Act).								
	<u>X</u>	Provided:	<u>X</u>	With limitation	ons				
		Not provide	ed.						
b.	Specia	al tuberculos	is (TB) rel	ated services	under secti	ion 1902 (z) (2) (F)	of the	Act.
		Provided:		With limitation	ons*				
	<u>X</u>	Not provide	ed.						
20.	Exten	ded services	for pregn	ant women		*	p.		
a.				partum service ne month in w				pregna	ancy ends
	<u>X</u>	Provided:		Additional c	overage ++				
b.	Servic	ces for any o	ther medic	cal conditions	that may co	omplicate	pregnanc	y.	
	<u>X</u>	Provided:		Additional c	overage ++	<u>_X</u>	_ Not	provide	d.
Attach descri	ed is a bed in t	description this attachme	of increase ent and/or	es in covered any additiona	services be I services p	yond limit rovided to	ations for	r all grou it wome	ups n only.
21.	Ambu period	latory prenat I by an eligib	tal care for le provide	pregnant wor r (in accordan	men furnish	ned during tion 1920	a presur	nptive e xt).	ligibility
	<u>X</u>	Provided:		No limitation	ns _. -	X Wi	th limitati	ons*	
		Not provide	ed.						
*Desc	ription	provided on a	attachmen	t.					············
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TN NO. MS-94-15

ATTACHMENT TO PAGE 7 Of Attachment 3.1-B

State: Nebraska

Major Categories of Services That Are Available As Pregnancy-Related services or Services For Any Other Condition That May Complicate Pregnancy

The Nebraska Medical Assistance Program covers the following major categories of services as pregnancy-related services or services for a condition that may complicate pregnancy:

1. All services covered under the Title XIX Plan are available when pregnancy-related or for a condition that may complicate pregnancy; and

2. The same limitations listed in Attachment 3.1-A are applied to pregnancy-related services or services for a condition that may complicate pregnancy.

Transmittal # MS-00-06

Supersedes

Approved DateMAR 1 0 2001

Effective Date 111 1 2000

Transmittal # MS-91-24

HCFA-PM-91-**MARCH 1987**

(BERC)

ATTACHMENT 3. 1-B Page 8

						OMB No.: 0938-0193
		State/Territory:	Nebraska			
						S PROVIDED
22.	Respi Act).	ratory care servic	es (in accorda	nce with se	ction 1902	(e)(9)(A) through (C) of the
		Provided:	No limi	tations		With limitations*
	<u>X</u>	Not provided.				
23.	Certif	ied pediatric or fa	mily nurse pra	ctitioners' se	ervices.	
	<u>X</u>	Provided:	No limi	tations	<u>X</u>	With limitations*
24.		other medical care		r type of ren	nedial care	e recognized under State law,
a.	Trans	sportation.				
	<u>X</u>	Provided:	No lim	itations	<u>X</u>	With limitations*
b.	Servi	ces of Christian S	Science nurses	3.		
		Provided:	No lim	itations		With limitations*
	<u>X</u>	Not provided.				
C.	Care	and services pro	vided in Christ	ian Science	sanitoria.	
		Provided:	No lim	itations		With limitations*
	<u>X</u>	Not provided.				
d.	Nurs	ing facility service	s for patients	under 21 ye	ars of age	
	<u>X</u>	Provided:	No lim	itations	<u>X</u>	With limitations*
e.	Eme	rgency hospital so	ervices.			
	<u>X</u>	Provided:	No lim	itations	_X_	With limitations*
*Des	cription	provided on atta	chment			
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Supe	ersedes	Approv	val DateMAR 1	<u>8 2001</u>	Effect	tive Date JUL 1 2000

TN NO. MS-87-11

Revision: HCFA-PM-94-9 (MB) ATTACHMENT 3.1-B Page 8b DECEMBER 1994 State: Nebraska AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): ____ All groups Home and Community Care for Functionally Disabled Elderly Individuals, as defined. 25. described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A. Provided not provided 26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home. State Approved (Not Physician) Service Plan Allowed Х Provided: Services Outside the Home Also Allowed Limitations Described on Attachment Not Provided.

TN NO. MS-00-06

Supersedes

Approval Date AR 16 2001

Effective Date JUL 1 2000

TN NO. MS-94-018

2/14/01 "

ATTACHMENT 3.1-B Page 9

Telehealth Service means any contact between a patient and a health care practitioner relating to health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care providers.

Health care practitioners must:

- 1. act within their scope of practice;
- 2. be enrolled with NMAP; and
- 3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

Medicaid services covered under the State Plan but specifically excluded from telehealth coverage are:

- 1. Medical equipment and supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
- 2. Orthotics and prosthetics provided by DME suppliers and pharmacies;
- 3. Personal Care Aide (PCA) services;
- 4. Home Health Aide services;
- 5. Pharmacy services for prescribed drugs;
- 6. Home and Community Based Waiver services provided by persons that do not meet the standards for practitioner of telehealth services;
- 7. Mental health, substance abuse, and psychiatric rehabilitation services provided by persons that do not meet the standards for practitioner of telehealth services;
- 8. Medical transportation services, including ambulance services;
- 9. Federally Qualified Health Center core services billed as an "encounter" service;
- 10. Rural Health Clinic core services billed as an "encounter" service;
- 11. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification;
- 12. Tribal 638 clinic core services billed as an "encounter" service;
- 13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings:
- 14. Services provided in public schools by staff who are not licensed, certified, or registered with Nebraska HHS Regulation and Licensure; and
- 15. Ambulatory room and board services.

Transmittal # MS-00	-06					
Supersedes	Approved _	MAR 1 ? 2001	Effective	JUL	1 2000	_
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ATTACHMENT 3.1-B Page 10

Services provided via telecommunications are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

This requirement does not apply:

- 1. In emergency or urgent medical situations;
- 2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
- 3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

Transmittal # MS-00-06

Supersedes

Approved MAR 1 5 2001

Effective

JUL 1 2000

Transmittal # (New Page)

ATTACHMENT 3.1-A Item 1a Applies to Both Categorically and Medically Needy

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State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

Reimbursement for inpatient hospital care of patients whose primary care needs are psychiatric in nature are limited to a hospital or distinct part of a hospital that -

- 1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
- 2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services Regulation and Licensure, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
- Is accreditated by the Joint Commission on Accreditation of Healthcare Organizations or American Osteopathic Association;
- 4. Meets the requirements for participation in Medicare for psychiatric hospitals; and
- 5. Has in effect a utilization review plan applicable to all Medicaid clients.

Transmittal # MS-00-06		MAD 1 C 2	0001			_
Supercedes	Approved _	MAR 1 6 2	Effective	JUL	1 2000	
Transmittal # MS-95-13						

ATTACHMENT 3.1-A Item 1c Applies to Both Categorically and Medically Needy

STATE PLAN UNDER TITLE XIX-OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

NMAP covers medical transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the appropriate staff in the Medicaid Division shall determine whether the transplant is medically necessary and non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance Program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that -

- 1. No other therapeutic alternatives exist; and
- 2. The death of the patient is imminent.

NMAP requires prior authorization of all transplant services before the services are provided.

NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment of complications is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

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Transmittal # M						
Supercedes	Approved	MAR 10 2001	Effective	JUL	1 2000	
Transmittal # M	IS-86-14					